|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [Payer name:] |  | RE: | [Patient name:] |  |
| [Address:] |  |  | [Member ID:] |  |
| [Phone:] |  |  | [Policy group:] |  |
| [Fax:] |  |  | [Date of birth:] |  |
|  |  |  |  | (mm/dd/yyyy) |

[Date]

Attn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am contacting you as a healthcare provider caring for [patient name] regarding the patient’s diagnosis of [diagnosis (ICD-10 code)].

I recently prescribed this patient ZORYVE® (roflumilast) cream, 0.15%, which required a prior authorization that was filed on [date]. The prior authorization was denied, and the patient was unable to fill their prescription. I have reviewed the patient’s diagnosis, care plan, and clinical guidelines for treatment and ***request a formal appeal of your denial for ZORYVE***.

I believe that treatment with ZORYVE is medically necessary for [patient name]. ZORYVE cream, 0.15%, is indicated for the topical treatment of mild to moderate atopic dermatitis in adult and pediatric patients 6 years of age and older.

Patient’s Medical History and Treatment Rationale: [You may want to consider including the following information, depending on your patient’s history of treatment with ZORYVE and the insurer’s reasons for denial.]

* [Patient’s history, diagnosis, current condition (eg, signs, symptoms), and previous therapies (if any)
* Patient's response to previous therapies and reasons for discontinuations (if any)
* Rationale for prescribing ZORYVE and, if applicable, dates of ZORYVE initiation and last refill as well as the rationale for delays in refills (if any)
* Summary of your professional opinion and potential prognosis for treatment with ZORYVE or the clinical response to ZORYVE treatment and impact on patient’s daily life]

When treating a patient with [diagnosis (ICD-10 code)], it is necessary to have access to the full spectrum of accepted treatments as patients may not be able to use one particular treatment due to lack of response or potential side effects. Based on the information provided above, I believe it is medically necessary for my patient to be treated with ZORYVE.

Additionally, I request that you review the following evidence showing how this medication can be effectively utilized to treat [diagnosis (ICD-10 code)]:

**1.** Simpson EL, Eichenfield LF, Gooderham M, et al. Efficacy and safety of roflumilast cream 0.15% in adults and children aged ≥6 years with mild to moderate atopic dermatitis in two Phase 3 trials (INTEGUMENT-1 and INTEGUMENT-2). Presented at: American Academy of Dermatology (AAD) Annual Meeting; March 17-21, 2023; New Orleans, LA, USA. **2.** Simpson EL, Eichenfield LF, Papp KA, et al. Long-term safety and efficacy of roflumilast cream 0.15% in adults and children aged ≥6 years with mild to moderate atopic dermatitis: a 52-week, Phase 3, open-label safety trial. Presented at: Revolutionizing Atopic Dermatitis (RAD) Conference;June 8-10, 2024; Chicago, IL, USA.

Please see INDICATION and IMPORTANT SAFETY INFORMATION.

**INDICATION**

ZORYVE cream, 0.15%, is indicated for topical treatment of mild to moderate atopic dermatitis in adult and pediatric patients 6 years of age and older.

**IMPORTANT SAFETY INFORMATION**

ZORYVE is contraindicated in patients with moderate to severe liver impairment (Child-Pugh B or C).

**IMPORTANT SAFETY INFORMATION (cont’d)**

The most common adverse reactions (≥1%) for ZORYVE cream 0.15% include headache (2.9%), nausea (1.9%), application site pain (1.5%), diarrhea (1.5%), and vomiting (1.5%).

Please see full [Prescribing Information](http://arcutis.com/zoryve-pi-hcp) for ZORYVE.

On behalf of [patient name], I would appreciate your prompt reconsideration of this denial. Please feel free to contact me at [prescriber’s phone number] for any additional information you may require. I look forward to receiving your response and approval of coverage for this medication.

Sincerely,

[Prescriber]

[Prescriber title/contact info]

ICD-10=International Classification of Diseases, Tenth Revision.

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